

# MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035672

OFFICE OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 362 Primary Registration District No. 4531 Registrar's No. 46

RECEIVED

FILED SEP 28 1961

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WARREN</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WARRENTON</u>	Length of stay in 1b <u>2 mo. 4 days</u>	c. CITY OR TOWN <u>St. Charles</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>KATIE JANE MEYER HOME</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>633 Monroe</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (First Middle Last) <u>GUSTAV (August) F. Rohlfing</u>			<b>4. DATE OF DEATH</b> (Month Day Year) <u>September 22-1961</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>2/1/1891</u>	<b>9. AGE (last birthday)</b> <u>70</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>21</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>PIPE FITTER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>A.C.F. Industrial</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>St. Charles, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>Herman Rohlfing</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Julianna Meyer</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>None</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give way or dates of service) <u>Yes WORLD WAR I</u>			<b>16. SOCIAL SECURITY NO.</b> <u></u>		<b>17. INFORMANT</b> (Address) <u>Lillian Schuttenberg - St. Charles Mo</u>		

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cirrhosis of liver with hepatic coma</u>		<u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypostatic Pneumonia</u>	<u>4 days</u>
	DUE TO (c) <u>Arteriosclerotic heart disease with congestive failure</u>	<u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____			

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b> _____ <b>STATE</b> _____
<b>21. I attended the deceased from</b> <u>July 18, 1961</u> to <u>Sep't. 23, 1961</u> and last saw <sup>her</sup> him alive on <u>9-22-61</u> Death occurred at <u>2:00 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

<b>22a. SIGNATURE</b> (Degree or title) <u>[Signature]</u>		<b>22b. ADDRESS</b> <u>[Address]</u>	
<b>22c. DATE SIGNED</b> <u>9-23-61</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>	<b>23b. DATE</b> <u>Sept. 25, 1961</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lutheran Mem.</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Charles, Mo.</u>
<b>24. FUNERAL DIRECTOR</b> (ADDRESS) <u>Arthur C. BAVE, St. Charles, Mo.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-25-61</u>	
<b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 29 1961

OCT 3 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John C. Smith

Licensed Embalmer No. 5145

P. O. Address St. Charles

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.